FOR OFFICE USE ONLY

MIG Dentistry, P.L.L.C.
1809 Golden Trail Ct. Suite 100
Carrollton, TX 75010
(972)492-0204

Insurance Policy

We have contracted with many insurance carriers to be providers on their plan. Contractually, both the provider and the patient have certain obligations under these plans.

1. We ask for your portion of the payment at the time the services are rendered. This is more efficient for our office staff and cost effective for our office.

2. We will ask for verification of your dental insurance at each visit. Many times insurance companies have various addresses and phone numbers, and they often change. Providing us with this information at each visit helps us to confirm that all of the important details are correct. If we do not have proof of a valid insurance, we will hold the patient responsible for the full amount of the services. The insurance discounted fees will not be applicable in these circumstances.

3. After your insurance company has paid their portion, if there is any amount not covered due to your deductible or non-covered services, we will send you a bill for the amount due. We ask that you remit that owed amount upon receipt of the bill.

4. Many insurance plans have exclusions and restrictions. It is the patient's responsibility to be aware of your benefit's limitations and restrictions. It is not possible for our practice to be aware of all the different benefit plans and restrictions, and we do not have access to the actual policies. In addition, the insurance companies also tell us that verification of benefits does not guarantee payment.

5. There is quite a bit of bureaucracy with insurance dental plans. There may be certain circumstances where we will ask you to get involved with your insurance carrier by phone to assist us in providing you with the necessary care, or in getting your claim paid. We feel that you, as the policyholder, should have a direct part in this.

6. Please notify the front desk if any information has changed since your last visit. If in the event a claim is filed to insurance and denied payment as a result of incorrect carrier or patient information, the balance IN FULL is due by the patient and future claim filing will be the patient's responsibility.

I have read and understand the above policies, and agree to cooperate and adhere to them.

Patient Signature

Date